North Carolina Department of Health and Human Services
Division of Medical Assistance - Provider Services
2501 Mail Services Center
Raleigh NC 27699-2501

801Ruggles Drive
Raleigh NC 27603

Thank you for your interest in providing additional services as a Community Alternatives Program (CAP) provider with the NC Medicaid Program.

Group Applicant

- ☐ Community Alternatives Program Addendum to add services. Original Signature Required. White out and alterations are not accepted. Please do not highlight any information on the addendum.
- ☐ Copy of Notification of Endorsement Action by the Local Management Entity or CAP/MR-DD Letter of Attestation, whichever is applicable.
- ☐ Name on addendum must exactly match name on original Medicaid Participation Agreement.
- ☐ Attachment C - Letter of Attestation for False Claims Act Education (required for all providers).
- ☐ Provider completes and signs the addendum and returns along with the required credentials to:

  DMA Provider Services
  Attn: CAP Provider Enrollment Specialist
  2501 Mail Services Center
  Raleigh, NC 27699-2501

Providers are requested to include on their addendum the name, e-mail address, and fax number of the individual at their site that is responsible for receiving Medicaid information.

Providers will be notified by mail once these additional services have been approved for enrollment. Please do not submit claims for any services until you have received notification of your provider number, and its effective date. Billing information and medical coverage polices are available on DMA's website at http://www.ncdhhs.gov/dma/prov.htm.

Thank you again for your interest, if you have any questions or need additional information, please feel free to contact your CAP Provider Enrollment Specialist at 1-919-855-4050.

DMA Website – http://www.ncdhhs.gov/dma/

INSTRUCTIONS FOR APPLICATION ACKNOWLEDGEMENT CARD

Please fill in the information below.
This is our method of acknowledging receipt of your application.

PLACE A STAMP ON THE ACKNOWLEDGEMENT CARD TO ENSURE DELIVERY BY THE POST OFFICE.

Provider Services
DHHS/DMA
2501 Mail Services Center
Raleigh NC 27699-2501

PLACE STAMP HERE. POST OFFICE WILL NOT DELIVER WITHOUT PROPER POSTAGE.

_____
Name

_____
Address

_____
City State Zip Code

Write your Medicaid provider number here:

34 ☐ ☐ ☐ ☐ ☐

CAP Addendum
Acknowledgement Card

Dear Provider:

We have received your application for re-enrollment in the NC Medicaid Program. Our standard processing time is approximately 6-8 weeks from the date of receipt of a complete and correct packet. Incorrect or incomplete packets will be returned to you.

Return of this acknowledgement card certifies that DMA has received your addendum packet. Please allow for our processing time before making status inquiry calls, as this may delay the processing time.

Thank you again for your participation in the NC Medicaid Program.

Sincerely,

DMA Provider Services

Date of Receipt

North Carolina Department of Health and Human Services
Division of Medical Assistance - Provider Services - 919-855-4050
Community Alternatives Program Services Addendum to Add Services

STATE USE ONLY
[ ] Initial Enrollment
[ ] Re-enrollment
[ ] CHOW
[ ] Other Change

ADDENDUM TO NORTH CAROLINA PROVIDER PARTICIPATION AGREEMENT

This addendum shall become part of your participation agreement with the NC Medicaid Program. As an approved Medicaid Provider of Community Alternatives Program Services, I herby submit this Addendum to add the following services.

Current CAP Medicaid Provider Number: 34 ☐☐☐☐☐

Indicate the Community Alternatives Program Services your business/agency is adding:

1. CAP/DA (Disabled Adult) Services

- ☐ Adult Day Health Care
- ☐ Case Management
- ☐ Home Delivered Meals
- ☐ Home Mobility Aids
- ☐ In-Home Aide Level II
- ☐ In-Home Aide Level III Personal Care
- ☐ Medical Supplies
- ☐ Personal Emergency Response System (PERS)
- ☐ Respite Care – In-Home
- ☐ Respite Care – Institutional
- ☐ Waiver Supplies

2. CAP/C (Disabled Children/Katie Beckett) Services

- ☐ Case Management
- ☐ Home Mobility Aids
- ☐ Hourly Nursing
- ☐ Medical Supplies
- ☐ Personal Care
- ☐ Respite Care – In –Home (Aide)
- ☐ Respite Care – In-Home (Nursing)
- ☐ Respite Care – Institutional
- ☐ Waiver Supplies

3. CAP-MR/DD (Mentally Retarded/Developmentally Disabled) Services

- ☐ Adult Day Health Care
- ☐ Augmentative Communication Devices
- ☐ Crisis Respite
- ☐ Crisis Services
- ☐ Day Supports
- ☐ Home and Community Supports
- ☐ Home Modifications
- ☐ Home Supports
- ☐ Individual/Caregiver Training & Education
- ☐ Long-term Vocational Supports
- ☐ Personal Care Services
- ☐ Residential Supports
- ☐ Respite Care- Facility Based with 24 hrs awake staff
- ☐ Specialized Consultative Services
- ☐ Respite Care – Noninstitutional Community Based
- ☐ Respite Care – Noninstitutional Nursing-Based
- ☐ Respite Care – Institutional
- ☐ Specialized Equipment and Supplies
- ☐ Supported Employment
- ☐ Transportation
- ☐ Vehicle Adaptations
- ☐ Personal Emergency Response System (PERS)*
  *PERS does not require endorsement.

Type or Print All Information in Blue or Black Ink

Name of Provider (must exactly match the name on Medicaid Participation Agreement):

_____

Doing Business As (if applicable): _____

Telephone Number: (_____) _____ - _____

Fax Number: (_____) _____ - _____

Email Address:_____

Site Address: _____
Street

_____ _____
City & State Zip Code + Four (Last 4 digits required)

County: _____

Payment/Mailing Address: _____
Street or Post Office Box

_____ _____
City & State Zip Code + Four (Last 4 digits required)

Contact Person's Name:_____

Contact Person's Telephone Number: (_____) _____

A. If you are enrolling as a group provider, list all shareholders/partners (including self) who have 5% or more ownership AND all individual officers, directors, managers, and Electronic Funds Transfer (EFT) authorized individuals and information requested on each. If you are an individual, enter name, address, title, and social security information for yourself only.

Name and Address	Title	SSN	License #	% Owner
	Check business relationship that applies: ☐ Owner ☐ Shareholder ☐ Partner			
Check relationship to enrolling provider: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling				

Name and Address	Title	SSN	License #	% Owner
	Check business relationship that applies: ☐ Owner ☐ Shareholder ☐ Partner			
Check relationship to enrolling provider: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling				

Name and Address	Title	SSN	License #	% Owner
	Check business relationship that applies: ☐ Owner ☐ Shareholder ☐ Partner			
Check relationship to enrolling provider: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling				

Name and Address	Title	SSN	License #	% Owner
	Check business relationship that applies: ☐ Owner ☐ Shareholder ☐ Partner			
Check relationship to enrolling provider: ☐ Spouse ☐ Parent ☐ Child ☐ Sibling				

B. Have you, or individuals or organizations having a direct or indirect ownership or control interest of five percent (5%) or more in this business been convicted of a criminal offense related to the involvement of such persons or organization in the programs of Medicaid (Title XIX) or Social Services Block Grant (XX)?
☐ **Yes** ☐ **No** **(If you answered 'Yes', attach explanation)**

C. Have any of your directors, officers, agents or managing employees of your group been convicted of a criminal offense related to their involvement in the program of Medicaid, Medicare or Social Services Block Grant?
☐ **Yes** ☐ **No** **(If you answered 'Yes', attach explanation)**

D. Have civil monetary penalties ever been levied against this agency by Medicare, Medicaid or other State or Federal Agency or Program?
☐ **Yes** ☐ **No** **(If you answered 'Yes', attach explanation)**

E. Have you or any of the individuals listed in Item 'A' ever:

a. Been convicted of a felony, had adjudication withheld on a felony, pled no contest to a felony or entered into a pre-trial agreement for a felony?
☐ **Yes** ☐ **No**

If yes, list the name(s) of the individual(s) and provide a copy of the administrative complaint and final disposition:
____

____

b. Had any disciplinary action taken against any business or professional license held in this or any other state? Or had your license to practice restricted, reduced or revoked in this or any other state?
☐ **Yes** ☐ **No**

If 'Yes' to 'E b', complete below and attach a copy of the final disposition. Attach documentation from the proper authorities that approve the reinstatement of the license:

Against Whom?	Action Taken?	Who took Action?	Date of Action?

c. Been denied enrollment, been suspended or excluded from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that has ever been suspended or excluded from Medicare or Medicaid in any state?
☐ **Yes** ☐ **No**

If 'Yes', list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation:

Name	Provider Number

d. Had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that had suspended payments from Medicare or Medicaid in any state?
☐ **Yes** ☐ **No**

e. Owes money to Medicaid or Medicare that has not been paid?
☐ **Yes** ☐ **No**

F. Is the organization/agency incorporated?
☐ **Yes** ☐ **No**
If yes, please attach a copy of Application for Incorporation, copy of Certified Articles of Incorporation and any subsequent changes to the Application/Articles of Incorporation.

CERTIFICATION STATEMENT:

The Undersigned certified the following:

- Provider attests that the contents of this application are true, accurate, and complete.
- There has been no: Change in ownership
  Site, location or agency
  Tax reporting or agency
- Provider understands that some changes may require additional information or a new application process.
- All information on file with the Division of Medical Assistance is current and correct.
- I agree to abide by the laws, regulations and program guidelines applicable to the services I have hereby applied to render.
- Provider certifies that they meet the qualifications and standards defined in the services definitions for the services herein requested.
- Providers agrees to provide such services within the guidelines of the most current service definitions(s) approved by the Division of Medical Assistance.

Signature of Authorization Required:

****Information Must Be Entered Fro The Agreement To Be Processed****

I certify that the above information is true and correct. I further understand that any false or misleading information may be cause for denial or termination of participation as a Medicaid Provider. Individual agreements must have the provider's original signature. Authorized agents can only sign for group agreements.

_____

Signature of Applicant or Authorized Agent **Date**

_____

Printed Name and Title

INTERNAL USE BY THE DIVISION OF MEDICAL ASSISTANCE

EFFECTIVE DATE:

This agreement is executed and shall become effective on the _____ day of _____ in the year of _____.

The agreement shall remain subject to renewal on a periodic basis. A new agreement may be required as DMA necessitates, by operation of law, Medicaid regulations, polices or other material circumstances, or termination upon substitution of a new agreement, or by act of the parties as herein provided. You are herein authorized to provider services of which are in accordance with the approved services definitions.

DMA APPROVAL:
Accepted on _____ by _____

Attachment C

LETTER OF ATTESTATION

The Deficit Reduction Act (DRA) of 2005, which went into effect January 1, 2007, required specific changes to states' Medicaid programs. One of the changes is the requirement for employee education about false claims recovery. Section 6032 of the DRA amended the Social Security Act, Title 42, United States Code, Section 1396(a) by inserting an additional relevant paragraph (68). This paragraph is cited below; in summary it requires any entities that receive or make annual payment under the Medicaid State Plan of at least five million dollars to have detailed, specific written policies established about the Federal and State False Claims Acts for their employees, agents and contractors**.**

Specifically, §1396(a)(68) of the Social Security Act requires that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall –

(A) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under section 3729 through 3733 of title 31, United States Code [31 USCS §3729-3733], administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code [31 USCS §. 3801 et seq.], any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f)[42 USCS § 1320-7b(f)]);

(B) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(C) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of the employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

Effective January 1, 2007, all providers who meet the above conditions are required to certify that they are in compliance with §1396(a)(68) of the Social Security Act as a condition of enrollment in the North Carolina Medicaid Program.

As a North Carolina Medicaid provider, or the owner/ operator/ manager of a North Carolina Medicaid provider entity, I certify that our entity has read and understands the above requirements. I also certify that if our entity receives or makes annual payments under the State plan of at least $5,000,000 we have complied with and established written policies and procedures that provide detailed information concerning the Federal False Claims Act, 31 USC 3729 *et seq.,* administrative remedies for false claims and statements established under 31 USCS §. 3801 *et seq.,* and any North Carolina State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs.

I further certify, when the above conditions apply, that our entity's written policies include detailed provisions regarding our policies and procedures for detecting and preventing fraud, waste, and abuse; and that our employee handbook contains a specific discussion of the Federal and State False Claims Acts, the rights of the employees to be protected as whistleblowers, and our policies and procedures for detecting and preventing fraud, waste, and abuse.

Copies of any and all training manuals, written policies and procedures for detecting and preventing fraud, waste, and abuse, and employee handbooks will be maintained on-site for a minimum of five (5) years for inspection and auditing by the Division of Medical Assistance

_____ _____

Signed Date

_____

Printed Name

_____

Relationship to entity (owner, operator, manager, CFO, self, etc)

STATE USE ONLY
Medicaid Provider Number:

_____